PATIENT QUESTIONNAIRE

Name:_____ Date:_____
Date of Birth:_____
Occupation:_____
Diagnosis:_____
Date of Injury or onset:_____
Date of surgery:_____
Referring Physician:_____

What are your symptoms? _____
_____
_____

How did your injury occur or your symptoms begin?_____
_____
_____

Pain level: 0= no pain, 10= excruciating pain (please circle the appropriate number)
Today's pain: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Nature of symptoms (circle all that apply)
Sharp Dull Throbbing Aching Periodic Constant Intermittent Other_____

What aggravates your symptoms?(Circle all that apply) Lying Sitting/Rising Standing Walking Bending/Stooping In/Out of car Other_____

What relieves your symptoms? Lying Sitting Standing Walking Resting Medication Exercise Nothing Massage Heat Ice Wearing a splint/orthotics

Does this injury/pain awaken you at night? Yes No If pain awakens you, can you get back to sleep? Yes No Position(s) of comfort: _____

If you have back/neck pain, does coughing worsen your symptoms? Yes No If you have back/neck pain, do symptoms radiate down into arms or legs? Yes No If yes, which side? Right Left Both

Have you experienced any unexpected weight loss recently? Yes No

Any recent X-rays, MRI, or diagnostic ultrasound tests? Yes No

List medications for current problem.
_____

List other medications you are currently taking._____
_____

Past medical History (please list accidents, falls, surgeries, current or chronic illnesses)_____
_____

Please place a mark on the line below indication your current activity level (i.e. are you able to participate and do the activities you want to with your current injury)
No activities _____ _____normal activities
Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain .
(///) Stabbing (xxx)Burning (+++) Aching (000) Pins & Needles (= = =) Numbness